State of Montana
Department of Corrections
Youth Services Division
Representative Payee Cancellation Request

Fax to (406) 441-1065

Youth's Name: [youth's full name]

Youth's Social Security Number:

Youth's Date of Birth:

Date Youth Left Care:

Returned To: [placement]
Address: [address]
[city], [state] [zip code]

Phone: ( ) -

Other info:

Statement of **Montana Department of Corrections**

The Department of Corrections should no longer be payee for this youth, and the benefits should be suspended until a new payee is selected.

Employee Signature: _____
Title: Regional Administrative Officer
Phone: ( ) -
Date: